MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Edward P. Kaup

Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0401-NF	**Comments Due:**	2/27/04	**Proposed Effective Date:**	3/15/04

Mail Comments to:
Mary Gear
Long Term Care Services
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: 517-335-5827

Fax Number: 517-241-8995
E-mail Address: gearmar@michigan.gov

Policy Subject: Medicaid Nursing Facility Beds Certification Process and Medicaid Provider Enrollment

Affected Programs: Medicaid

Distribution: Nursing Facilities

Policy Summary:

This policy lifts the Upper Bed Limit on Medicaid nursing facility bed certifications, defines the Medicaid bed certification process, and requires dual (Medicare/Medicaid) certification for all new beds.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Nursing Facilities

Issued: XX/XX/XX

Subject: Medicaid Certification and De-certification of Nursing Facility Beds and Medicaid Provider Enrollment

Effective: March 15, 2004

Programs Affected: Medicaid

This policy bulletin describes the process by which Medicaid certifies and de-certifies nursing facility (NF) beds and how nursing facility providers enroll in Medicaid. This policy also requires Medicare certification of all new Medicaid-certified beds.

The State Medicaid Agency (SMA) is responsible for the initial certification and annual re-certification of beds for nursing facilities seeking Medicaid reimbursement. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The State Survey Agency (SSA) is responsible for conducting any required certification surveys.

Section 1: Dual Certification

Medicaid strongly encourages Medicare and Medicaid (dual) certification of all NF beds in order to maximize access for beneficiaries. State law requires that any NF participating in the Medicaid (Title XIX) program must also be certified for, and give evidence of, participation in the Medicare (Title XVIII) program. With the effective date of this bulletin, Medicaid requires that all Medicaid-certified NF beds also be certified for Medicare. Requests for new Medicaid bed certification of NF beds that are not Medicare certified will be denied. Medicaid beds that are not Medicare-certified on the effective date of this bulletin will automatically be granted an exception to this requirement.

NF beds currently designated Medicaid-only may seek annual re-certification from the SMA under their current designation. Those beds that are certified as Medicaid-only on the effective date of this bulletin will be grandfathered in and are not required to be Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on the effective date of this bulletin. A NF that had beds granted an exception under this policy and that is subsequently involved in circumstances that would require it to re-seek Medicaid provider enrollment (e.g., a change in ownership) must secure Medicare certification for Medicaid beds within one year. A provider's failure to secure dual certification for all Medicaid-certified beds will result in denial of Medicaid re-certification and disenrollment from the program.

A provider that requests new Medicaid certification for some beds in a nursing facility must dually-certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the beds were granted an exception under this policy. For example, a nursing facility has a distinct part unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and requests Medicaid certification for the new beds. The new beds would be

approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit.

A licensed NF entity that becomes a provider as a result of the purchase of a recently closed or current Medicaid-only NF must receive Medicare certification for all Medicaid-certified beds in that nursing facility within one year from the date of purchase of an operating nursing facility or the date of reopening of a previously closed nursing facility. The provider will receive a provisional Medicaid provider agreement while pursuing Medicare certification of the Medicaid-certified beds. This provisional agreement is time limited and holds the provider to the loss of Medicaid certification and disenrollment without appeal if Medicare certification is denied. If warranted, the SMA may grant an additional grace period contingent upon evidence that substantial progress has been made toward Medicare certification. Failure to meet this requirement will result in de-certification of the Medicaid beds and termination of the Medicaid Provider Agreement.

A NF that currently has Medicare certification of its Medicaid beds must maintain the dual certification. A NF that voluntarily disenrolls or de-certifies beds from Medicare will lose Medicaid certification of those beds. A nursing facility that loses its Medicare certification through the Centers for Medicare and Medicaid Services (CMS) regulatory enforcement actions will automatically lose its Medicaid certification. An exception or exemption to this dual certification may be made pursuant to the provisions contained in Section 21718 of P.A. 368 of 1978 (MCLA 333.21718). Any exception or exemption granted to a NF under Section 21718 of P.A. 368 of 1978 prior to the effective date of this policy will be recognized.

Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit Beds, are also required to dually certify some types of special population beds. ICF/MR or MI beds need not be dually certified.

A provider must request and receive dual Medicaid and Medicare certification for all bed increases acquired through the CON process (new construction) or the redistribution (existing) of Medicaid certifications.

Section 2: Medicaid Nursing Facility Bed Certification

2.1 Criteria for Evaluation of Medicaid Bed Certification Requests

The SMA will collaborate with the SSA when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDCH for Medicaid bed certifications will be based on the following criteria:

- Verification from the SSA that the beds are also certified for Medicare.
- The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility must not have been the subject of one of the following actions or concerns, and must not have shared a common owner or management company with a nursing facility that has been the subject of one of the following actions or concerns, within three years of the filing of an application for Medicaid bed certification:
    - A state enforcement action involving license revocation, a limited or total Ban on Admissions, reduced license capacity, selective transfer of residents, receivership, or appointment of a clinical advisor or temporary manager.
    - Termination of a Medicaid Provider Agreement initiated by MDCH.
    - Failure to comply with state or federal staffing requirements.

- A state or federal finding of Immediate Jeopardy.
- A pattern of repeat citations at the harm or substandard quality of care level.
- A pattern of citations on three consecutive surveys that exceeds the statewide average number of citations by two times.
- A number of citations or substantiated complaints in excess of the statewide average for any calendar year.
- A federal or state termination or de-certification action.
- A federal or state action to deny payment for new or all admissions.
- A filing of bankruptcy or failure to meet financial obligations or other concerns related to the ability of the nursing facility, or its owners or management company, to achieve or maintain compliance.
- An outstanding debt to MDCH (i.e., cost settlement, civil monetary penalty [CMP] fine, provider bed tax, licensing fees). This does not include financial issues that are in the appeal process.
- Failure to comply with a state correction notice order.
- Enforcement action against the administrator's license in current or previously administered nursing facilities.
- Any other concerns reasonably related to the ability of the nursing facility, or its owners or management company, to maintain compliance with Conditions of Participation and to provide appropriate care to residents.

- If currently enrolled as a Medicaid provider, in addition to the criteria above, must be a provider in good standing, which is defined as a provider where:
  - The nursing facility, owner(s), administrator, or staff are not sanctioned or excluded by Medicare or Medicaid;
  - The nursing facility and provider are in compliance with the Medicare and Medicaid Conditions of Participation.

Medicaid may enter into a provider agreement to certify Medicaid beds on a conditional basis with a provider (or its owner or management company) that does not meet the above criteria if:

- The applicant and its owner or management company take actions acceptable to MDCH to correct, improve or remedy any conditions or concerns that would result in denial of the application; and
- The applicant and its owner or management company attains and maintains compliance with the criteria above during the period of the provisional provider agreement. Failure of the provider to comply with the terms of the conditional agreement will result in termination of the provider agreement without appeal.

2.2 Medicaid Nursing Facility Bed Certification Process

Current providers who wish to change their Medicaid certified beds and providers who wish to enter the Medicaid program may do so by following the process outlined below.

A provider may request a change in Medicaid bed certification at the time of their annual survey and any time throughout the year up to once per quarter. The change in bed certifications will take place effective with the beginning of the next quarter after approval is granted.

In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Section 3202.

MDCH will respond to Medicaid bed certification requests within 45 days.

2.2.A Bed Certification Process For Medicaid Enrolled Providers

Nursing facilities that are currently enrolled with Medicaid and that want to change the number of Medicaid certified beds must file a written request with their SSA licensing officer and with the Medicaid agency, MDCH LTC Services. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for additional Medicaid bed certifications. The SSA will conduct surveys as required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin.

Once Medicaid makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the MDCH LTC Rate Setting section will be notified in writing. If the request is denied, the provider will be notified in writing of their appeal rights. If the request is approved, the SSA will be given approval to issue a new Notice of Licensure/Certification Action (LC-180) reflecting the change.

2.2.B Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid

The following applies to providers operating existing facilities that have not participated in the Medicaid program before, or providers seeking to re-certify Medicaid beds following the loss of certification due to a regulatory action.

Non-Medicaid providers seeking to receive Medicaid certification for NF beds and receive Medicaid payment must file a written request with their SSA licensing officer and with the Medicaid agency, MDCH LTC Services. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. The SSA will conduct surveys as required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the LTC Rate Setting section will be notified in writing. If the request is denied, the SMA will notify the provider of their appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

The provider must also enroll as a Medicaid provider as outlined in the Medicaid Provider Enrollment section of this bulletin.

2.2.C Bed Certification Process during a Change in Ownership (CHOW)

A provider seeking a change in ownership of a NF must first receive approval through the CON process within MDCH. The new provider can avoid a delay in payment and address any potential certification issues by sending a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to their SSA licensing officer, the LTC Services section and the LTC Rate Setting section.

The following are changes in ownership that must be reported to the SMA and SSA, regardless of whether a CON is required:

- A change from sole proprietorship to partnership or corporation,
- A change from partnership to sole proprietorship or corporation,
- A change from corporation to sole proprietorship, partnership or corporation,
- Sale or lease of a nursing facility, or
- Transfer of stock.

If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were under the previous owner. However, as part of the CHOW approval process, the SMA may deny bed certifications and recommend against provider enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin. In addition, dual certification requirements apply as outlined in the Dual Certification section of this bulletin.

If the new owner wants to change the bed certifications, they must file a written request with their SSA licensing officer and with the Medicaid agency, MDCH LTC Services. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for additional Medicaid bed certifications. The SSA will conduct surveys as required. Medicaid approval or denial of the application will be based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Requests section of this bulletin.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the LTC Rate Setting section will be notified in writing. If the request is denied, the SMA will notify the provider of their appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

A new owner is considered a new provider and must enroll as a Medicaid provider as outlined in the Medicaid Provider Enrollment section of this bulletin, regardless of whether any bed certification changes are made.

2.2.D Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds

A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license NF beds must first receive approval through the CON process within MDCH.

Providers seeking to receive Medicaid certification for the new NF beds and receive Medicaid payment must file a written request with their SSA licensing officer for a certification survey, and file a request with MDCH LTC Services. The SMA and the SSA will coordinate regarding the consideration and disposition of the request for Medicaid bed certifications. Medicaid approval or denial of the application will be based on the Criteria for Evaluation of Medicaid Bed Certification Requests.

Once the SMA makes a determination regarding the request for additional Medicaid bed certifications, the provider, the SSA, MDCH Provider Enrollment, and the LTC Rate Setting section will be notified in writing. If the request is denied, the SMA will notify the provider of their appeal rights in writing. If the request is approved, the SMA will authorize the SSA to issue a new LC-180 reflecting the change.

If not already enrolled, the provider must enroll as a Medicaid provider as outlined in the Medicaid Provider Enrollment section of this bulletin.

Section 3: Medicaid Provider Enrollment

To enroll with Medicaid, a NF provider must:

- Receive written notice from the SMA indicating approval for Medicaid bed certifications.
- Receive an LC-180 from the SSA indicating authorization for Medicaid bed certifications. This document must indicate Medicare certification of the new Medicaid certified beds.
- Complete a New Provider Information Packet to establish data with the LTC Rate Setting section. Requests for a New Provider Information Packet may be made to the LTC Rate Setting section at 517-335-5356. New Provider information can also be found on the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Long Term Care Provider Forms.
- Complete a Provider Enrollment Agreement. Requests for a provider enrollment application may be made to MDCH Provider Enrollment at 517-335-5492.

  A provider will not be enrolled with Medicaid, which includes issuance of provider ID number for billing, until MDCH Provider Enrollment has received, at least:

  - A copy of the letter from MDCH authorizing the CON (for new providers and CHOW).
  - Written notice from MDCH LTC Services that the nursing facility has been approved for Medicaid bed certifications. This will include a copy of the LC-180 indicating dual certification (Medicare) for the new Medicaid-certified beds.
  - Notice from the LTC Rate Setting section that the provider has the required data on file.
  - A completed Provider Enrollment Agreement.

NF providers are also encouraged to enroll with the State of Michigan Vendor and Contractor Payment System in the event that Medicaid must issue payment outside of the claims processing system (i.e., an emergency payment voucher). Providers can enroll on-line at www.cpexpress.state.mi.us or call the Payee Registration Helpline at (517) 373-4111 (Lansing area) or (888) 734-9749. **NOTE:** In order for the SMA to issue an emergency payment voucher, the Federal Employer ID number registered with the Vendor and Contractor Payment System must agree with the Federal Employer ID on file with the LTC Rate Setting section.

Section 4: Loss or Reduction of Medicaid Certification

4.1 Notification Process for Regulatory Actions

MDCH or CMS may make decisions that result in the loss or reduction of a provider's Medicaid certified beds. Loss of certification or de-certification means that Medicaid will no longer pay for any service in the nursing facility.

MDCH or it's designee notifies the following of the loss of Medicaid certification at least 30 days prior to the effective date of payment termination:

- The affected nursing facility,
- The local Family Independence Agency (FIA) office, and
- Publishes public notice in a local newspaper.

This notification of the nursing facility's loss of certification will state that residents must either:

- Make other arrangements for payment to the nursing facility; or
- Relocate to a setting that is Medicaid certified.

The provider may request assistance from FIA to coordinate relocation for those beneficiaries who wish to transfer. MDCH may choose to apply the Nursing Facility Closure Protocol noted below to protect the best interests of residents faced with transfer.

4.2 Nursing Facility Closure Protocol

An interagency agreement exists, including the SMA, the Office of Services to the Aging (OSA), the SSA, and FIA, to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, a nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.

4.3 Voluntary Withdrawal from Participation in the Medicaid Program or Voluntary Nursing Facility Closure

A provider may choose to close voluntarily, not as a result of regulatory action. A provider may also choose to continue operating as a nursing facility, but withdraw from participation in the Medicaid program. In both situations, the NF must follow established guidelines to assure safe and appropriate care of residents.

When a provider decides to voluntarily terminate Medicaid participation or close voluntarily, it must provide written notice at least 30 days before transfer or discharge to residents and, if known, a family member or legal representative of the resident. This notice must include contact information for the LTC Ombudsman. The provider must submit written notification of termination at least 90 calendar days prior to the termination to MDCH Provider Enrollment Unit, LTC Rate Setting section, the SSA licensing officer, MDCH LTC Services, and the local FIA office. The provider is responsible for the safe and appropriate re-location of all residents.

In the event of a voluntary closure, the nursing facility remains Medicaid certified until all residents are relocated. In the event of withdrawal from Medicaid participation, the nursing facility remains certified until all Medicaid beneficiaries are relocated.

The interagency agreement referenced in the Nursing Facility Closure Protocol section of this bulletin address voluntary closures as well as regulatory closures, and outlines the responsibilities of the state agencies involved. The SSA monitors the withdrawal or closure of a nursing facility. The provider may request FIA assistance with resident relocation if needed.

If the provider does not fulfill its responsibilities for the safe and appropriate relocation of residents, as reported by the SSA, the State Closure Team may change the closure into a regulatory action. At that point, the closure becomes non-voluntary and the State Closure Team may request the assistance of a closure agent. The interagency agreement referenced in the Nursing Facility Closure Protocol section of this bulletin would apply.

Section 5: Re-Entry after De-certification

A nursing facility may re-enter the Medicaid Program after de-certification (whether voluntary or involuntary) if the following conditions are met:

- Submission of a request for re-admission to the SSA, including documentation indicating that the factors leading to a regulatory termination no longer exist.
- Evidence that all of the applicable statutory and regulatory requirements have been met.
- There is reasonable assurance that the deficiencies that caused the termination will not reoccur.
- The facility is concurrently pursuing Medicare certification.

Upon re-entry into the program, all Medicaid beds must also be Medicare certified.

The process for re-entering the Medicaid program includes:

Application	The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and Medicaid for review and processing. A nursing facility may apply for re-certification at any time.
Departmental Review	The SMA makes a formal review of the nursing facility's financial status and requests confirmation of compliance with all Civil Rights requirements from the Office of Civil Rights (OCR). If financial responsibility and requirements of program participation are confirmed, a reasonable assurance period (not subject to appeal) is set and the SSA is asked to conduct an initial survey.
Survey Activity	There will be at least two surveys during the reasonable assurance period. • Initial Survey - A survey is conducted at the beginning of the reasonable assurance period to document compliance on previous deficiencies. The initial survey may be a partial or full survey at the discretion of MDCH. A finding of substantial compliance at this survey will allow the nursing facility to begin the reasonable assurance period. If the nursing facility is found to not be in substantial compliance, then they must re-apply. • Second Survey - A full survey must be conducted and the nursing facility must be in substantial compliance in order for the reasonable assurance period to end. The SSA will schedule the survey to coincide with the end of the

	established reasonable assurance period. If the nursing facility has maintained compliance during the reasonable assurance period, it may be approved for Medicaid participation. If the nursing facility is not in substantial compliance at the second survey, it must enter another reasonable assurance period. • General Survey Protocol - Facilities are afforded the same rights for challenging survey results as in the standard certification process, which is through the administrative review process within the SSA. During the reasonable assurance period, the SSA may conduct as many surveys as approved by Medicaid to document compliance with program requirements. Surveys are unannounced; therefore, the nursing facility will only receive acknowledgement of receipt of the approved application and that program enrollment is based on the outcomes of the surveys conducted. All survey reports (CMS-2567L) are forwarded to Medicaid within ten working days to determine the significance of any findings and the resultant action plan. The results of survey are evaluated to ensure that the reasons for the termination no longer exist or are at levels of substantial compliance (Level 1 – Cells A, B or C). Facilities are notified of the determination in writing. If the SSA determines that the conditions for re-entry are met, then Medicaid participation will be approved. If the SSA determines that the conditions for re-entry have not been met, then the SSA will send the provider a denial letter. The nursing facility may correct the deficiencies and re-apply for certification, resulting in another reasonable assurance period.
Reasonable Assurance Period	The reasonable assurance period is designed to assure that a nursing facility can operate for a certain period of time without the re-occurrence of the deficiencies that led to termination from participation in the program(s). Medicaid contacts the SSA to conduct surveys during the reasonable assurance period. The reasonable assurance period begins when the initial survey is completed, which assures MDCH that the nursing facility is complying with requirements for which they were originally decertified. The SMA will establish a reasonable assurance period of 30 to 180 days. However, it may be shorter or longer depending on circumstances. The length of the reasonable assurance period is not subject to appeal. The time frame for reasonable assurance is based upon criteria, which may include the following: • When the provider previously participated in the Medicaid program, was compliance maintained consistently? • When plans of correction were required, were they implemented on time? • Does the provider have a history of good faith efforts to correct deficiencies and maintain compliance? • Does the nursing facility have a history of repeat citations for the same problems? • Were adverse actions initiated, but not put into effect? • Does the nursing facility have a history of termination and re-admission to the program? • How long was compliance maintained after re-admission back into the program? • Have all deficiencies been corrected? Are corrective actions likely to continue?

	• Are there other factors present that may indicate that compliance could be questionable, i.e., staffing concerns, turnover, and pay scale? The SMA will not grant program participation until the reasonable assurance period has been satisfied. During the reasonable assurance period, the nursing facility must: • Employ adequate management and care staff to provide care in accordance with all applicable federal, state and local regulations. • Limit admissions to two residents per day or four residents in a seven-day period, regardless of payment source. • Develop an admissions informed consent document that is acceptable to the SMA and which explains the re-entry process. The document should further explain to the resident (or authorized representative) that their residency in the nursing facility could be temporary and a transfer to another setting may be necessary if the nursing facility fails to meet all of the requirements for certification. This notice must be explained to, and signed by, the resident or their authorized representative. A signed copy of this document must be placed in the resident's record.
Appeals Procedure	An applicant may appeal a denial of Medicaid participation by submitting a written request within 60 days of the date of the denial decision. The appeal should be addressed to the MDCH Administrative Tribunal and Appeals Division. The written appeal must include documentation to support the appeal. If the applicant fails to submit documentation within the 60 days, then the denial decision remains in effect.
Payment	Providers are eligible for Medicaid reimbursement when the nursing facility has been found to meet the conditions for re-entry and is an enrolled Medicaid provider.

Section 6: Unavailable Beds

Any nursing facility bed is considered available for occupancy if the bed is licensed and Medicaid certified unless it is removed from service due to a regulatory ban on admissions or voluntarily using the State's unavailable bed policy.

Medicaid allows nursing facilities to designate beds as unavailable, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Nursing Facility reimbursement policy.